

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ST. MARY'S HOSPITAL.

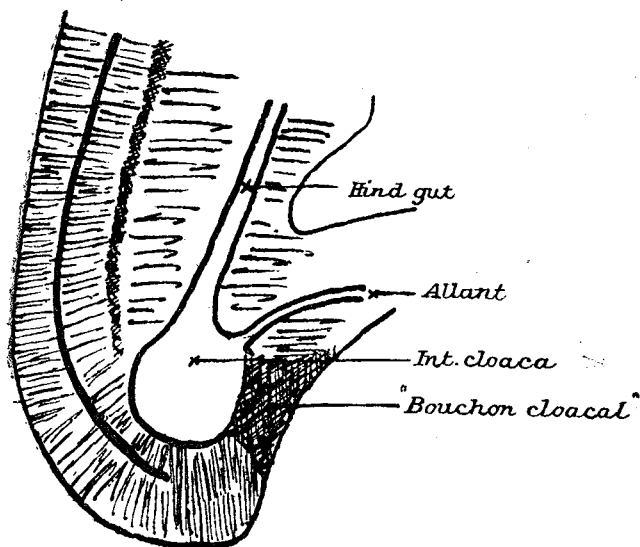
A CASE OF A RARE VARIETY OF MALFORMATION OF THE ANUS.

(Under the care of Mr. STANSFIELD COLLIER.)

For the notes of the case we are indebted to Dr. Geoffrey Bate, late house surgeon.

A healthy-looking child, aged five months, was taken to St. Mary's Hospital on account of the pain suffered when passing motions. On examination the following condition was found. The middle line behind the scrotum was occupied by a thick fold of skin, about one and a half inches long, continuous in front with the median raphé of the scrotum and attached posteriorly just behind the anal opening. The fold was laterally compressed by the buttocks and faeces passed equally freely on either side of it. The skin forming this bridge over the anus was similar to that of the scrotum, had a very slightly marked median raphé, and contracted slightly on stimulation. Under an anæsthetic the whole fold was easily dissected off; it was then seen that the anus was abnormally small; this was dilated at intervals for some weeks and the child now passes motions freely and without pain and the appearance of the parts is normal.

Remarks by Dr. BATE.—I am indebted to Mr. Stansfield Collier for permission to report the above case of a comparatively rare variety of malformation of the anus which is of particular interest as emphasising the importance of the "anal membrane" and the so-called "bouchon cloacal" in the formation of the ano-rectal tube. Neither Bodenhamer nor Giralde's, in exhaustive treatises on malformations of the



rectum and anus, mentions any such anomalous condition as this, but Harrison Cripps, classifying anal malformations in five groups, describes as his fourth group those cases in which "the anus and bowel may be perfectly formed but the outlet obstructed by a tail-like fold of skin extending from the scrotum to the tip of the coccyx." He reports three cases, one in his own experience and two recorded by Morgan from the Hospital for Sick Children, Great Ormond-street, in *THE LANCET* of Oct. 22nd, 1881, p. 705. The formerly accepted view that the ano-rectal tube is formed by the meeting of an ectodermal depression with the hind gut could not account for the malformation above described. The later view—that the anus is formed by the absorption of a definite cellular mass, in which the absorptive process commences laterally—is capable of explaining this malformation, and probably also the variations of the hymeneal orifice.

The "definite cellular mass" above referred to is known as the "bouchon cloacal," described by Tourneux as a specialised part of the anal membrane forming the anterior wall of an internal cloaca at the junction of the allantoic stalk with the hind gut (see figure). The anal membrane is, at first, however, a middle-line structure, most evident centrally, thinning off laterally; hence the process of absorption of the "bouchon" would tend to be incomplete in the middle line at a stage when a complete opening had been formed on either side. In this way, possibly, the tail-like band of tissue seen in this case may have had its origin.

VICTORIAN EYE AND EAR HOSPITAL, MELBOURNE, AUSTRALIA.

A CASE OF SUTURE OF AN UNHEALED CORNEAL INCISION
19 DAYS AFTER EXTRACTION OF CATARACT.

(Under the care of Mr. JAMES P. RYAN.)

A MAN, aged 48 years, of spare habit and in ordinary health, was admitted into the Victorian Eye and Ear Hospital on Jan. 22nd, 1904. His right eye was blind from an injury received some years previously and being tender to the touch and irritable-looking was excised on the 27th. The cornea of the left eye was much damaged and opaque (except in its upper third) from former keratitis and lead deposit. The pupil dilated only partially and irregularly on account of adhesions to the anterior capsule, the lens appeared to be hazy, and his vision amounted to counting fingers with difficulty at from seven to eight inches. The prospect of doing anything to restore useful vision seemed remote but as in his present helpless state the man was debarred from earning a livelihood, and as he was most anxious that something should be undertaken with the object of improving his condition and was willing to take all the risks, Mr. Ryan decided upon removing his lens. However, it was not quite ripe and for safety sake a preliminary iridectomy was done early in April and on May 18th the operation for extraction was performed. This entailed no special difficulty and was followed by rather less than the normal reaction but the corneal operation wound remained unhealed and after some days the vitreous began to protrude. Compression with pad and bandage was applied for nearly a fortnight without effect and, as there was the greatest danger of the contents of the eyeball being squeezed out on any slight exertion on the part of the patient, it appeared to Mr. Ryan that nothing short of closing the corneal incision would, in the circumstances, be effectual. Accordingly on June 6th, 19 days after the extraction, the protruding vitreous body being gently and gradually pressed within the globe and held back by a fine spud, the lips of the wound were drawn together by two fine silk sutures passed through the whole thickness of the sclera. They were removed eight days afterwards when it was found that the operation wound was completely and evenly healed. Local anæsthesia by means of cocaine was employed and antisepsis (imperfect no doubt) was procured by carefully cleansing the field of operation with warm saturated boric lotion and by the frequent instillation of cyanide of mercury solution (1 in 2000). Mr. Ryan had no great difficulty in steadying the edges of the corneal wound while the needles were being passed and at the same time, with the help of an assistant, in keeping back the vitreous while the sutures were being tightened.

Remarks by Mr. RYAN.—One might reasonably enough have predicted in this case the non-union of surfaces which had not been "freshened." It may be that some attachment between them and the vitreous had formed and that the breaking down of such adhesions whilst the vitreous was being forced back produced some "rawing" of the opposing lips of the wound. The result may be deemed sufficiently good when from having been practically blind the patient has recovered an amount of vision which renders him more or less independent of others and enables him to do something towards earning a livelihood. I can find no allusion in the text-books to such a procedure as the above having been employed, though I am aware that scleral wounds have been stitched. I have myself done so on several occasions and with gratifying results and the result seemed to me to be no valid reason why a similar practice should not be carried out in gaping wounds of the cornea.